DeVore Dermatology, P.A.

KAREN A. DEVORE, M.D.
490 FLOYD ROAD
SPARTANBURG, SC 29307

TEL: (864) 596-7546
FAX: (864) 596-7549
www.devoredermatology.com

Dear Friends and Patients:

Thank you for choosing DeVore Dermatology, P.A. for your dermatological care. Our goal is to provide quality medical care in an efficient matter. Please feel free to give us feedback on what we do well, as well as what we can improve upon.

In order to assist us in this goal, please complete the enclosed forms and bring them to your scheduled appointment. Please arrive 15 minutes early and bring with you:

- a current picture ID
- insurance card(s)
- medicine list
- allergy list
- credit, debit or health savings card

Please be familiar with what your insurance company requires. If you need a referral to see a specialist, please call a day or two before your appointment to make sure we have received it from your primary care doctor.

We collect all applicable copayments/coinsurance and deductibles at time of service. We accept cash, checks, Visa, MasterCard, and Discover.

We now request a debit, credit or health savings card on file for all accounts. We will still continue to file your insurance; however, we have had an increased problem collecting what insurance does not pay (co-pays, deductibles, percentage after insurance pays). Any amount the insurance states is your responsibility will be applied to the card on file. We take high priority in protecting your credit card information. Please ask us if you have questions.

If in the event you are unable to keep your appointment, we kindly ask that you give a 2 business day notice so that we may pass on your appointment slot to someone else who needs it. There is a $40 charge for last minute cancellations or no shows.

Prescription requests will only be considered during normal business hours - not after hours or on weekends or holidays, so please plan ahead. It is in your best interest that we have your medical record with a list of your current medications and allergies when refilling medications. There is a $10.00 charge for refilling prescriptions without an appointment.

Thank you again for your patience and trust. It is my pleasure to care for you and your family.

God Bless You,
Karen A. DeVore, M.D. and staff

How To Find Us

From Mary Black Hospital:

Once on Skylyn Drive, Mary Black Hospital should be on your left. At the first traffic light after the hospital, make a left. This is Floyd Road. Our office is 1/4 mile on the left.

From Gaffney, Gastonia, Charlotte:

Merge onto I-85 South.
Take the US-221 exit, Exit #78
Turn left onto US-221/Chesnee Hwy.
Go approximately 1 1/2 miles
At the light at Liberty Methodist Church,
Turn left onto Floyd Road
Our office is 1 1/2 miles on the right.

From Greenville:

Merge onto I-85 North
Take the US-221 exit, Exit #78
Turn right onto US-221/Chesnee Hwy.
Go approximately 1 1/2 miles
At the light at Liberty Methodist Church,
Turn left onto Floyd Road
Our office is 1 1/2 miles on the right.

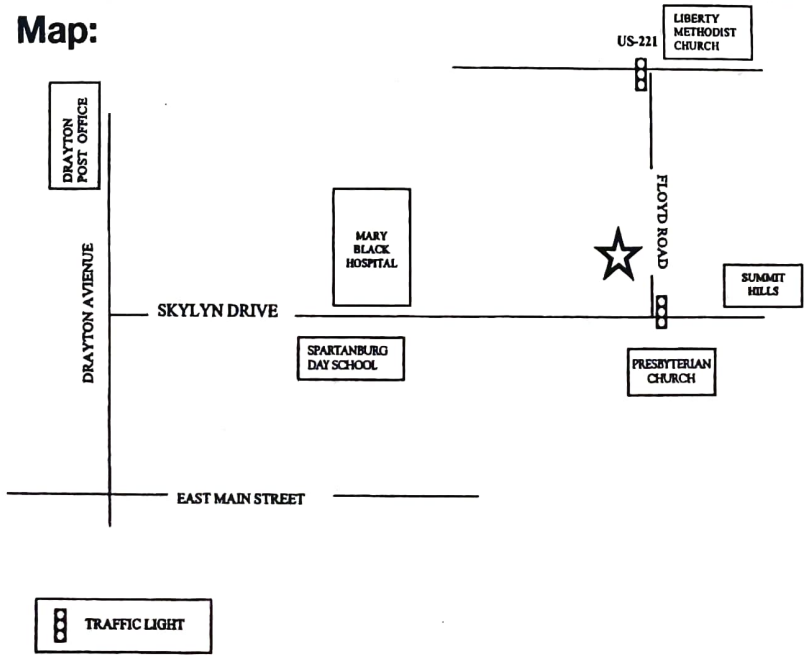
From I-26 East:

Take I-26 East to I-85 North
Merge onto I-85 North via Exit #18B toward Charlotte.
Take the US-221 exit, Exit #78
Turn right onto US-221/Chesnee Hwy.
Go approximately 1 1/2 miles
At the light at Liberty Methodist Church,
Turn left onto Floyd Road
Our office is 1 1/2 miles on the right.

From I-26 West:

Take I-26 West to I-85 North
Merge onto I-85 North via Exit #18B toward Charlotte.
Take the US-221 exit, Exit #78
Turn right onto US-221/Chesnee Hwy.
Go approximately 1 1/2 miles
At the light at Liberty Methodist Church,
Turn left onto Floyd Road
Our office is 1 1/2 miles on the right.

Map:



DeVore Dermatology, P.A. • 490 Floyd Road • Spartanburg • 864-596-7546

UNIVERSAL MEDICATION FORM

Date form started:

Name:	**Address:**
Phone Number:	
Birth Date:	
Emergency Contact/Phone Numbers:	

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)		
TETANUS	FLU VACCINE(S)	
PNEUMONIA VACCINE	HEPATITIS VACCINE	OTHER

Allergic To / Describe Reaction:	**Allergic To / Describe Reaction:**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginko). Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATION/DOSE	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	Notes: Reason for taking / Doctor Name

Refer to back of form for directions, benefits of using the form, and how to get more copies.

InHealth Record Systems A3962 UM (07.25.17) To Reorder: Call 800-809-5131 (In Atlanta) 770-396-0047 (By Email) sales@inhealth.us (Online) www.inhealth.us

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Consent to Wireless Telephone calls: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the doctor's office to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the doctor's office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

Signature: _____ Date: _____

Consent to email usage: If at any time I provide my email address at which I may be contacted, unless I notify the doctor's office to the contrary in writing, I consent to receiving communications regarding billing and payment for items and services at the email address from the doctor's office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

Signature: _____ Date: _____

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PATIENT INFORMATION SHEET

DATE: _____ SOCIAL SECURITY # _____

Name _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____

Email Address: _____

SEX _____ DATE OF BIRTH _____ MARITAL STATUS _____

FAMILY DOCTOR/INTERNIST/PRIMARY CARE PHYSICIAN _____

REFERRED BY: _____

EMPLOYER _____ STUDENT: YES NO

IF PATIENT IS MARRIED, SPOUSE'S NAME _____ WORK# _____

IF PATIENT IS A CHILD, FATHER'S NAME _____ WORK# _____

MOTHER'S NAME _____ WORK# _____

Responsible Party

Name (FIRST, MI, LAST) _____

SOCIAL SECURTY # _____ D.O.B. _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____

OTHER INFORMATION

CONTACT PERSON NOT LIVING WITH YOU _____ RELATIONSHIP TO PATIENT _____

HOME PHONE # _____ CELL PHONE# _____ WORK PHONE # _____

INSURANCE INFORMATION

PRIMARY _____

GROUP# _____ POLICY# _____

POLICY HOLDER _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

SECONDARY _____

GROUP# _____ POLICY# _____

POLICY HOLDER _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

PLEASE COMPLETE MEDICAL HISTORY ON REVERSE SIDE

FOR OFFICE USE ONLY:
DATE: _____
PHYSICIAN: _____
CHART #:

MEDICAL HISTORY

CHART # _____

Please thoroughly complete this history form to help ensure the best possible medical treatment.

Patient: _____ Age: _____ Today's Date: _____

Reason for visit: _____
How long have you had this problem? _____
What treatment have you used on your own? _____
What prescription treatments have been used? _____
Are you **ALLERGIC TO ANY MEDICATIONS?** If so, please list: _____
_____

List any **medications** you are **currently taking** and circle the approximate **length of time** that you have been on the medication:

1)	_____	less than one year	1-2 years	more than 3 years
2)	_____	less than one year	1-2 years	more than 3 years
3)	_____	less than one year	1-2 years	more than 3 years
4)	_____	less than one year	1-2 years	more than 3 years
5)	_____	less than one year	1-2 years	more than 3 years
6)	_____	less than one year	1-2 years	more than 3 years
7)	_____	less than one year	1-2 years	more than 3 years
8)	_____	less than one year	1-2 years	more than 3 years

**If you are taking more than 8 medications, please continue on the back of this form.

Have you had **aspirin or ibuprofen** in the last two weeks? ❒ yes ❒ no
Have you ever had **dental anesthesia** (novocaine)? ❒ yes ❒ no
If yes, any bad reactions? _____
Do you smoke? ❒ yes ❒ no If yes, how much? _____
Do you drink alcohol? ❒ yes ❒ no If yes, how many drinks per day? _____
Do you use IV drugs? ❒ yes ❒ no If yes, what kind? _____
Have you ever had or been exposed to HIV (AIDS)? ❒ yes ❒ no
Have you ever had or been exposed to Hepatitis? ❒ yes ❒ no
When you are exposed to the sun do you: ❒ Tan only ❒ Tan and Burn ❒ Burn
Have **you** ever had **skin cancer**? ❒ yes ❒ no If yes, was it melanoma? _____
Has a **family member** had **skin cancer**? ❒ yes ❒ no
If yes, was it **melanoma**? ❒ yes ❒ no If yes, whom? _____
Do you have a history of any specific **skin diseases**? ❒ yes ❒ no
If yes, please list the type: _____
Do you have artificial joints? ❒ yes ❒ no
Do you bleed easily? ❒ yes ❒ no
Do you faint easily? ❒ yes ❒ no
(Women) Are you Pregnant? ❒ yes (due date) _____ ❒ no
What **blood relative** has:
Diabetes _____ Asthma _____ Hay fever _____
Skin disease _____ What type? _____
Do **you** have any of the following conditions?
Diabetes _____ Asthma _____ Hay fever _____ Heart disease _____
Lung disease _____ Stomach ulcers _____ High blood pressure _____
Are you under hospice care? ❒ yes ❒ no

FINANCIAL AGREEMENT

Please Initial Each Line

1. _____I understand payment is due at the time of service unless arrangements have been made in advance. Visa, MasterCard, Discover, and debit cards are accepted.
2. _____ I authorize DeVore Dermatology to file my insurance(s) as a courtesy to me and understand payment for these services will be mailed directly to this office.
3. _____ I recognize that ultimate financial responsibility for my account remains mine. If my insurance company does not pay the practice within a reasonable period, I will be responsible for the payment. If DeVore Dermatology receives a check from my insurance company they will refund any overpayment in excess of $5.00. Overpayments under $5.00 will show as a credit on my account.
4. _____ I understand that not all insurance plans cover all services. In the event my insurance plan determines a service to be "not covered" I will be responsible for the complete charge. I hereby guarantee payment in full of any and all charges for services rendered not covered by any health insurance plan, including all deductible and coinsurance amounts.
5. _____ **I understand that a copayment or coinsurance is required at the time of my visit.**
6. _____ All balances due after insurance must be paid in 60 days unless a written arrangement has been made.
7. _____ As a courtesy to others and to avoid a $40 service charge, we kindly ask that you give a 2 business day cancellation notice. We realize emergencies do arise and we will handle those on a case by case basis.
8. _____ I am aware that there may be a $10 administrative charge for phoning in prescriptions and a $25 administrative charge to complete any miscellaneous forms.
9. _____ We now request a debit, credit or health savings card on file for all accounts. Any amount the insurance states is your responsibility will be applied to the card on file. We do not send out bills for these balances. Use your EOB from your insurance company to show you what your responsibility would be.

_____ _____ _____

Patient Signature (or parent if a minor) **Print Name** **Date**

If you are not the patient, please state your relationship_____

MEDICARE PATIENTS ONLY:
STATEMENT TO ASSIGN MEDICARE BENEFITS TO PHYSICIAN OR SUPPLIER

Patient's Name:_____ Medicare Number:_____

"I request that payment of authorized Medicare Benefits be made on my behalf to DeVore Dermatology, P.A. for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services." Signature_____ Date_____

STATEMENT TO ASSIGN MEDIGAP BENEFITS TO PHYSICIAN OR SUPPLIER (SUPPLEMENTAL)

"I authorize Medicare to file my supplemental (Medigap) insurance. I request that payment be made to DeVore Dermatology, P.A. for any services furnished to me by that physician. I authorize the release of any medical information necessary to process this claim." Signature_____ Date_____

MEDICARE NON-COVERED SERVICES WAIVER

"I understand that there is a $10.00 charge for phoned in prescriptions (CPT 99371) and a $40.00 charge for missed appointments or appointments cancelled with less than a 2 business day notice. I am aware that these charges are not covered by Medicare and that I will be financially responsible for this charge if and when it is incurred.

Signature_____ Date _____Witness _____

I. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 864-596-7546 or by requesting one at the office.

_____ _____

Date Signature of Patient/Guardian Representative*

*If not the patient, please print your name and relationship to the patient: _____

DISCLOSURE TO OTHER PERSONS REGARDING YOUR HEALTH INFORMATION

(Please be aware that you may change this information at any time by requesting to complete a new form.)

This practice may disclose personal health information about you to your referring doctor, family doctor, family, close personal friends or any person that you identify, as long as the information disclosed to those individuals is relevant to their involvement in your care or the payment for your care. This practice may also notify a family member or another person who is responsible for your care of your location and general health condition.

_____I do not object to my personal health information being disclosed to a doctor, family member, friend or other individual involved in my care. Persons I authorize for disclosure: **(List specific names)** _____

_____

_____I object to my personal health information being disclosed to anyone other than myself.

II. LAB SERVICES

In the event that you have lab work done in this office, you may receive a bill for those services from another vendor.
A.) Pathology specimens will be sent to Celligent Diagnostics B.) Blood work will be sent to LabCorp
C.) I will be responsible for any amount insurance does not cover _____ _____

Patient or Guardian Signature Date

Read carefully before completing: If for insurance purposes pathology specimens or blood work need to be sent elsewhere please indicate where to send them below and notify the nurse at the time of the procedure. If at any time this information changes, it is the patients' responsibility to notify appropriate staff:

Pathology_____Blood work_____ Patient Signature_____

III. COSMETIC INTEREST

Please circle any cosmetic interests you would like to discuss with the doctor today.

Sclerotherapy (eliminates leg veins)

Smoothing Nasolabial Folds (smile lines)

Laser Hair Removal

Laser Removal of Vascular Lesions (blood vessels)

Microdermabrasion (exfoliates skin and cleanses pores)

Jane Iredale Mineral Makeup

Skin Care Products

Botox or Dysport (smooths frown lines)

Laser Skin Rejuvenation (treats fine lines and sun damaged skin, no down time, encourages collagen growth)

IV. How did you hear about us?

Physician Friend/Family

Internet Yellow Pages

Insurance Company

Seminar Other: _____